DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

TRANSMITTAL AND NOTICE OF APPROVAL OF	I. TRANSMITTAL NUMBER:	2. STATE
	}	
STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	03-13	Louisiana
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR	4. PROPOSED EFFECTIVE DATE	
HEALTH CARE FINANCING ADMINISTRATION	February 9, 2003	
DEPARTMENT OF HEALTH AND HUMAN SERVICES		
TYPE OF PLAN MATERIAL (Check One):  O NEW STATE PLAN OR AMENDMENT TO BE CONSIDERED AS	NEW PLAN <b>MAMENDMENT</b>	
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMEN		amendment)
6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:	
42 CFR 440.150	a. FFY 2003	\$3,386.11
THE CALL THUISO	b. FFY	\$6.657.31
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPER ATTACHMENT (If Applicable):	RSEDED PLAN SECTION OR
Attachment 4.19-D, Page 11	Same (TN 89-46)	
Attachment 4.19-D, Page 11.a.	New Page	
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FORM HCFA-179 (07-92)